



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

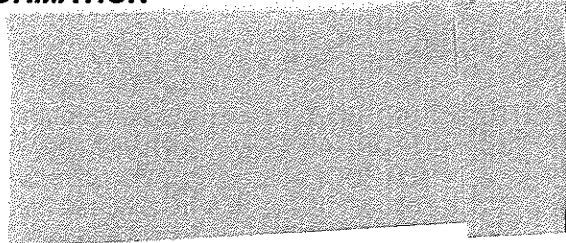
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TGZ ACQUISITION CO LLC DBA JACE
5 ROCKHILL RD SUITE 2
CHERRY HILL NJ 08003



Respondent Name

HOUSTON ISD

Carrier's Austin Representative Box

Box Number 21

MFDR Tracking Number

M4-12-2651-01

MFDR Received Date

April 17, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am appealing the denial on all claims referenced on the attaché EOR. Claims are denying due to lack of pre-authorization. Our customer service department received an order from the patient's doctor on 07/27/2011 for a shoulder CPM machine to be placed on the patient following his surgery. On 07/27/2011 our customer service department found the number for Avizent and called leaving a voice message on what o contact for authorization. We were unable to reach any person until 08/04/2011 when we were able to get a hold of a Tina Phillips, who in turn gave us the adjustor's name and number. Our customer service department then emailed the adjuster, Brenda Carr, in regards to approving a retro-authorization, as we were never informed of who we needed to contact for proper authorization. We were never advised at any time that we needed to receive pre-certification through any other company. We didn't receive any correspondence until our customer service department called Ms. Carr on 08/08/2011 to follow up on the email that was sent. We were then informed by Ms. Carr that we must just submit the claims without pre-certification, and that she would review them and may approve retro payment, or will submit them to the doctor to be reviewed for medical necessity."

Amount in Dispute: \$2,175.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor is seeking reimbursement for dates of service Jul 28, 2011, August 12, 2011 and August 19, 2011 in the amount of \$2,175.00. The dates of service at issue are for medical equipment that was ordered to be placed on the claimant. The equipment at issue was supposed to be pre-authorized and was not. The Carrier denied the bill based on lack of pre-authorization. As the denial was in accordance with applicable statutes and rules, no reimbursement is due."

Response Submitted by: Thornton, Biechlin, Segrato, Reynolds & Guerra, LC, 912 S. Capital of Texas Highway, Ste. 300, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 28, 2011 August 12, 2011 August 19, 2011	HCPCS Code E0936	\$2,175.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedures and guidelines for obtaining preauthorization.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 16, 2011, November 21, 2011 and March 6, 2012:

- 197 – Payment denied/reduced for absence of precertification/preauthorization.
- 217 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- 96 – non-covered charge(s).
- W1 – Workers Compensation State Fee Schedule adjustment.
- 193 – Original payment decision is being maintained. This claim was process properly the first time.
- PA – Prior allowed

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor receive preauthorization for the DME prior to the dates of service.?
3. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code §133.307(c)(2)(a) the requestor did not submit a copy of the medical bills, in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills). Per 28 Texas Administrative Code §133.307 the requestor has not met the requirements for filing medical fee dispute resolution.
2. Per 28 Texas Administrative Code §134.600(p) states that all non-emergency health care requiring preauthorization includes (9) all durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental). The requestor did not obtain preauthorization for the DME prior to the dates of service the equipment was used on the claimant.
3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement.

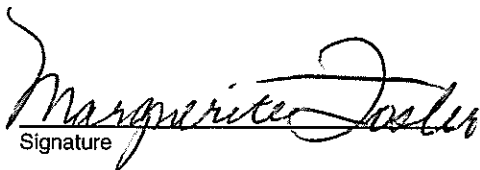
Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature



Signature

Marguerite Foster
Medical Fee Dispute Resolution Officer

May 31, 2012
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.